INPATIENT HOSPITAL PAYMENT METHODOLOGY

INTRODUCTION

The South Dakota Medicaid Program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Related Group (DRG) methodology since January 1, 1985.

GENERAL

South Dakota has adopted the federal definitions of Diagnostic Related Groups, the DRG classifications, weights, geometric mean length of stay, and outlier cutoffs as used for the Medicare prospective payment system. The grouper program is updated annually as of October 1 of each year. Beginning with the Medicare grouper version 15 (effective October 1, 1997), South Dakota Medicaid Program specific weight and geometric mean length of stay factors will be established using the latest three years of non-outlier claim data. This three year claim database will be updated annually in order to establish new weight and geometric length of stay factors with each new grouper.

Hospital specific cost per Medicaid discharge amounts were developed for all instate hospitals using Medicare cost reports and non-outlier claim data for these hospital's fiscal year ending after June 30, **1996** and before July 1, **1997**. An inflation factor, specific to the hospital's fiscal year end, was applied to the cost per discharge amounts of all hospitals with more than thirty (30) Medicaid discharges during the base year to establish target amounts for the period of October 1, **1998** through September 30, **1999**.

A cap on the target amounts has been established. Under this cap no hospital will be allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

Out of state hospitals will be reimbursed on the same basis as the hospital is paid by the Medicaid Agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, payment will be at 70% of billed charges. Payment will be for individual discharge or transfer claims only, there will be no annual cost settlement with out of state hospitals.

SPECIFIC DESCRIPTION

Target amounts for non-outlier claims were established by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, a hospital's target amount will be adjusted annual for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors.

The case mix index for a hospital was calculated by accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

The average cost per discharge for non-outlier claims was calculated by subtracting the charges for ancillary services on outlier claims, multiplied by the average ancillary cost to charge ratio, from the total allowable ancillary charges for the hospital. Total Medicaid days and discharges were reduced by the number of days and discharges from outlier claims to calculate the routine costs for non-outlier claims. Routine costs and ancillary costs related to non-outlier claims were added and then the total allowable costs were divided by the number of non-outlier discharges during the base period.

CAPITAL COSTS

Capital and education costs will be paid following the Medicare retrospective reasonable and allowable cost reimbursement methodology. The Medicare reduction of allowable cost for capital and education costs will not be used, rather 100% of allowable cost will be paid. Interim payments for capital and education costs will be made to instate hospitals that had more than thirty (30) Medicaid discharges during the hospital's fiscal year ending after June 30, **1996** and before July 1, **1997** on a perdiem basis. The interim rate is hospital specific and is calculated using the most recently reviewed Medicare cost report.

UPDATING OF TARGET AMOUNTS

Target amounts will be updated annually using the latest Consumer Price Index factor available at the time the new Medicare grouper is implemented each year (October 1). An adjustment will be made each year to correct any inaccuracy in the prior year's inflation factor.

TRANSFER PATIENTS

Payment will be allowed to the transferring hospital whenever a patient is transferred to another hospital regardless of whether the receiving hospital is paid under the DRG system or **is** an exempt hospital or unit.

The amount of payment made to the transferring hospital will be on a per diem basis. The per diem rate will be calculated by dividing the standard DRG payment for the particular stay by the geometric mean length of stay for the DRG. The per diem rate will then be multiplied by the number of days stay prior to the transfer. In no instance will the payment to the transferring hospital be any higher than the full DRG payment amount if the patient had been discharged home. The daily capital/education passthrough will be added to the DRG payment.

The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital.

COVERED DIAGNOSTIC RELATED GROUPS

South Dakota will adopt all DRGs, except DRG 436 and 437, established in the version of the grouper program being used by the Department as of the admission date on the claim.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The Department will adopt Medicare's definition of inpatient hospital services covered by DRG payment. As a result, billing for physician services must be made on a separate HCFA 1500 form.

OUTLIER PAYMENTS

Additional payments will be made to hospitals for discharges which meet the criteria of an "outlier". An outlier is a case that has extremely high charges which exceed cost outlier thresholds.

A claim will qualify for a cost outlier payment when 70% of billed charges exceed the larger of **$17,167** or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of **$17,167** or 1.5 times the DRG payment. Effective October 1, 1991, and annually thereafter, the cost outlier threshold will be inflated annually using the same inflation factor used in updating the target amounts.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.

PRIOR AUTHORIZATION OF SERVICES

Payment for the following procedures and services will be allowed only after authorization and approval by the Department of Social Services prior to admission. Procedures and services requiring prior authorization are:

1. Heart Transplants
2. Liver Transplants
3. Bone Marrow Transplants
4. Psychiatric Care in DRG Exempt Units
5. Neonatal Intensive Care in DRG Exempt Units
6. Rehabilitation Care in DRG Exempt Units

Approval or denial of the proposed procedures and services may be obtained by contacting the Department of Social Services, and providing appropriate supporting documentation.

INAPPROPRIATE SERVICES

When the medical need for a transfer cannot be demonstrated, payment will be limited to one DRG payment to the discharging hospital. To safeguard against these and other inappropriate practices, the Department of Social Services will monitor admission practices and quality of care issues through the South Dakota Peer Review Organization (PRO). Payment for inappropriate long term hospital care as determined by the PRO will be made on the basis of the current swing bed rate in South Dakota for the level of care the patient requires. In addition, all claims will continue to be subject to the review of the Department's physician consultant. The physician will refer questionable claims to the PRO for review/investigation.

If an abuse of the prospective payment system is identified, payment will be denied and the matter will be handled in an appropriate fashion.

EXEMPT HOSPITALS, UNITS, AND/OR PROCEDURES

As a result of their unique patient population, certain instate facilities and/or units may, upon request and showing the ability to provide cost and statistical data for the facility and/or unit, be exempted from the DRG system. **The Department may require certain instate facilities to be exempted from the DRG system.** In South Dakota exemptions include only the following:

1. Psychiatric Hospitals;
2. Rehabilitation Hospitals;
3. Perinatal Units (only upon request and justification) that have
   a. The capability of providing care for infants under 750 grams;
   b. The capability of providing care for infants on ventilators;
   c. The capability of providing major surgery for newborns;
   d. Twenty-four hour coverage of a neonatologist; and
   e. A maternal neonatology transport team;
4. Psychiatric Units (only upon request and justification);

5. Rehabilitation Units (only upon request and justification);
6. Children's Care Hospitals;
7. Indian Health Service Hospitals;
8. Hospitals with less than 30 Medicaid discharges **during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994; and**
9. **Specialized Surgical Hospitals.**

Payment for these in-state exempt facilities and/or units, except for psychiatric hospitals, psychiatric units, Indian Health Service hospitals, **Specialized Surgical Hospitals**, and instate hospitals with less than 30 Medicaid discharges **during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994**, will continue on the Medicare retrospective cost base system with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services that relate to exempt hospitals and units will be included as allowable costs.

2. Malpractice insurance premiums attributable to exempt units or hospitals will be allowed using 7.5% of the risk portion of the premium multiplied by the ratio of inpatient charges to total medicaid inpatient charges for these hospitals or units.

3. Psychiatric hospitals and psychiatric units will be paid on a per diem basis equal to the average per diem allowable costs for psychiatric hospitals and psychiatric units during fiscal year 1990. This per diem rate will be inflated annually using the same inflation factor used for target amounts.

Indian Health Service hospitals will be paid on a per diem basis as established by HCFA.

Instate hospitals with less than 30 discharges **during the hospital's fiscal year ending after June 30, 1993 and before July 1, 1994** will be paid at 95% of billed charges.

Specialized Surgical Hospitals will be reimbursed on a per diem basis equal to twice the per diem rate allowable for swing-bed hospitals as established in Attachment 4.19-D, Section D - Other, Provision 10.

EXCEPTION TO PAYMENT METHODOLOGIES FOR ACCESS-CRITICAL AND AT-RISK HOSPITALS

Hospitals that have been determined by the Department of Health to be above average access-critical and above average at-risk will be reimbursed at the greater of actual allowable cost or the payment received under the provisions contained in this attachment.

UPPER LIMITS

Payments in aggregate for inpatient hospital services will not exceed the amount that would be paid for services under Medicare principles.

APPEALS

The State Department of Social Services has administrative review procedures to meet the need for provider appeals required by 42 CFR 447.253(e).

ACCESS AND QUALITY OF CARE

All hospitals located in South Dakota are participating in the Medicaid program which results in the best possible access to hospital services for the Medicaid recipient.

Quality of care will be monitored by the South Dakota Professional Review Organization.

DISPROPORTIONATE SHARE PAYMENTS

An additional payment will be allowed to any hospital that has a disproportionate share of low income patients. The threshold at which an individual hospital will be deemed to be serving a disproportionate share of low income patients is when either the Medicaid inpatient utilization rate, as defined in section 1923(b)(2), is above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the state or the low-income utilization rate, as defined in section 1923(b)(3), exceeds twenty-five (25) percent. To qualify as a disproportionate share hospital a hospital must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals entitled to medicaid service, this requirement does not apply to hospitals whose patients are predominately under 18 years of age or which does not offer nonemergency obstetric services to the general population. For hospitals located in a rural area, the term "obstetricians" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. Beginning July 1, 1994, a hospital must also have a Medicaid utilization rate of at least one (1) percent to qualify for DSH payment.

If a hospital qualifies under both the Medicaid inpatient utilization rate and the low-income utilization rate the additional payment will be based on whichever utilization rate will result in the higher payment. Only one additional disproportionate share payment will be allowed to a hospital.

Effective April 1, 1996, qualifying disproportionate share hospitals shall be grouped into one of the following three groups:

Group 1: Acute care hospitals.

Group 2: Psychiatric hospitals operated by the State of South Dakota.
Group 3: Other hospitals. (Any hospital not in Group 1 or 2.)

Payments to Group 1 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 1 hospitals qualifying under low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - **$14,960**

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - **$23,000**

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - **$31,000**

if the qualifying rate is 3 or more standard deviations above the mean - **$39,000.**

Payments to Group 2 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - **$100,000**

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - **$250,000**

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - **$500,000**

if the qualifying rate is 3 or more standard deviations above the mean - **$751,299**.

Payments to Group 3 hospitals qualifying under Medicaid inpatient utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the Medicaid inpatient utilization mean for all participating hospitals. Payments to Group 2 hospitals qualifying under low-income utilization method will be based on the standard deviation that a facility's qualifying rate exceeds the low-income utilization mean for all

participating hospitals. Payment will be made according to the following schedule:

if the qualifying rate is greater than the mean rate to less than 1 standard deviation above the mean - $250

if the qualifying rate is 1 standard deviation above the mean to less than 2 standard deviations above the mean - $500

if the qualifying rate is 2 standard deviations above the mean to less than 3 standard deviations above the mean - $750

if the qualifying rate is 3 or more standard deviations above the mean - $1,000.

If necessary, payments to qualified hospitals will be adjusted for the projected impact of the hospital's specific disproportionate share hospital payment limit as required by ORBA`93.

Disproportionate share payments will be made one time during each state fiscal year. If the total of disproportionate share payments to all qualified hospitals for a year is going to exceed the State disproportionate share hospital payment limit, as established under 1923(f) of the Act, the following process will be used to prevent overspending the limit. First, the amount of over-expenditure will be determined. Then the over-expenditure amount will be deducted from the total payments to Group 2 hospitals. Payments to individual Group 2 hospitals will be reduced based on their percentage of Group 2 total payments.

Enclosure 3

Attachment 4.19 A

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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